STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G696	A. BUILDING 00 B. WING	10/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	336 W 56TH ST MERRILLVILLE, IN 46410

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W0000	This visit was for an extended recertification and state licensure survey. Dates of survey: October 9, 10, 11, 12 and 19, 2012 Facility number: 003103 Provider number: 15G696 AIM number: 200317190 Surveyor: Christine Colon, Medical Surveyor III/QMRP The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/30/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review and interview for 3 of 3 sampled clients (clients #1, #2 and #3), the facility failed to ensure the clients' rights by not obtaining a legally sanctioned decision maker to assist in medical and financial decisions. Findings include: 1. A review of client #1's record was conducted at the facility's administrative office on 10/10/12 at 2:35 P.M.. Client #1's record indicated she was an emancipated adult. Review of client #1's medical record indicated: Notation dated 4/19/12: "Hospital called Service Coordinator (SC) requesting a DNR (Do Not Resuscitate). SC informed them [client #1] signs for herself. They won't accept that due to history of alzheimers." Notation dated 4/19/12: "Hospital trying to reach family for consent for a PIC line and DNR."	W0125	The guardianship process has been started for 2 out of the 3 clients needing guardians. The third client remains in the hospital and family is determining whether they want to take guardianship. Service Coordinator will continue to seek alternate guardianship until guardians are secured for each client. (11/28/12) To ensure future compliance, Service Coordinator will monitor the guardianship process for completion.	11/28/2012

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Notation dated 4/20/12: "Hospital states the PIC line has become an emergency issue since its the only way they can get antibiotics into [client #1]."

Notation dated 4/22/12: "Group home staff called the SC stating that [client #1] has been moved to ICU (Intensive Care Unit) because she coded during the night and needed intubation...Doctor wants to scope her lungs in the morning in hopes to open any blockage that may be there."

Notation Dated 5/2/12: "SC visited [client #1]. She had been off the vent for a few days but had to be put back on."

Notation dated 5/4/12: "SC visited [client #1]. Kidneys have stopped functioning. She's on dialysis, most likely permanently."

Notation dated 5/10/12: "SC visited [client #1]. Remains on vent. Floor nurse stated she's unlikely to improve without a trach (tracheotomy-surgical hole that goes into windpipe and tracheotomy tube is put in it)."

Notation dated 5/14/12: "Group home staff called SC and stated that while at the hospital she was informed that the hospital has been trying to reach the

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	family regarding the trach situation. Unable to reach family." Notation dated 5/14/12: "Received a phone call from [Doctor name], he stated that the hospital has been unsuccessful in contacting client's relatives for a consent for a trach, which is needed asap (As soon as possible), or he feels she will worsen on the ventilator. SC notified, nurse also notified." Notation dated 5/18/12: "SC and hospital still unable to reach family. No answer and no return call from the many messages left. Hospital is considering appealing to the courts to have guardian appointed for her." Notation dated 6/18/12: "[Client #1] was discharged from [Hospital name]...She will be receiving dialysis 3 days a week." Notation dated 6/27/12: "Nursing assessment performed at client's home...Non-verbal, communicates with minimal sign language...Approximately 1-2 cm (centimeter), 0 depth open area noted to buttock, will obtain order tomorrow." Notation dated 10/1/12: "I received a phone call from group home, DSP (Direct Support Professional) on 9/29/12, stated			

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	that consumer went to [Dialysis Center name] for her dialysis treatment. Staff noted that after accessing her dialysis catheter a greenish substance excreted from the dialysis catheter port." Notation dated 10/2/12: "...Consumer was doing good although admitted due to Sepsis. She has a staph infection in her blood and a UTI (Urinary Tract Infection). Consumer is on two IV (Intravenous) antibiotics." The Conference Summary dated 7/1/12 indicated: "Needs assistance in making major life decisions." The Developmental Assessment dated 7/1/12 indicated: "Does not use money. She shops with very close supervision. Needs assistance in banking and budgeting." The Individual Support Plan (ISP) dated 7/15/12 indicated: "Individual's Diagnosis: Seizure Disorder, Hypertension, Hypothyroidism, Hearing Impairment...Comments: Receives anti seizure medications monitored by neurologist..Hypothyroidism, hypertension, severe arthritis, unsteady gait, fall risk, GERD (Gastro-Esophageal Reflux Disease) at risk for heartburn and discomfort and GI (Gastro Intestinal) bleeding, peripheral vascular insufficiency-swelling of legs, skin breakdown due to dermatitis...Will			

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	gesture information about medication...will continue to match coins to said like coins-match with identical likeness...Will learn to trace and or point to her address and telephone number...Will continue to learn/identify 4 new sign language words and to recognize and communicate with her communication book." The "Annual Team Meeting" dated 7/16/12 indicated: "[Client #1] is improving her health and safety skills by learning to identify where she takes her medication...The General Risk Factors Assessment was completed by the IDT (Inter Disciplinary Team) during this annual meeting. The IDT determined and agreed that she needs a Seizure, Hypothyroidism and Hypertension, and Fall High Risk Plan, risk for further skin breakdown related to dermatitis and increased incontinence, GERD, pain from arthritis." Further review of client #1's record failed to indicate she had any immediate family members that were actively involved. 2. A morning observation was conducted at the group home on 10/9/12 from 5:50 A.M. until 8:05 A.M.. During the entire observation client #2 sat in a wheelchair holding her head. Client #2 did not communicate and when asked questions looked off and then began holding her			

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	head with no response. A review of client #2's record was conducted at the facility's administrative office on 10/10/12 at 3:10 P.M.. Client #2's record indicated she was an emancipated adult. Review of client #2's medical record indicated: Notation dated 4/18/12: "[Client #2] was taken by staff to [Hospital name] ER (Emergency Room) because she was very unsteady on her feet and having difficulty walking. DX (Diagnosis) ear infection." Notation dated 5/22/12: "Received an incident report this afternoon from staff stating the [client #2] got up in the night, and without asking for staff assistance and fell hitting her left eye and nose. Left eye has 3 inch bruise above the eyebrow and nose has a small red area on the bridge. Ice pack applied." Notation dated 6/26/12: "Gait problems...Unable to stand or ambulate...unable to stand." Notation dated 6/27/12: "During a visit at the group home, staff stated there has been a noted change in condition, gait unsteady, occasional confused			

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	conversation." Notation Dated 6/28/12: "Patient was admitted for Dilantin toxicity." Notation dated 6/29/12: "Called [Hospital name] for F/U (follow up) on consumer. Consumer doing well, Dilantin level 38.5 (normal range is 10 to 20) at this time." Notation dated 7/2/12: "F/U call to [Hospital name]. Consumer doing well Dilantin level was 19.8. A ENT (Ear Nose and Throat) consult requested due to consumer having a sinus infection." Notation dated 7/15/12: "F/U call to [Hospital name]. Consumer is having procedure of Left Debridement Mastoid cavity done this morning...Dilantin level is 15.4." Notation dated 7/10/12: "[Client #2] was discharged on 7/9/12. She had a decrease in her Dilantin dose and four new medications." Notation dated 8/20/12: "Staff reported that consumer is getting worst (sic). She is not doing anything for herself. Stated also is wetting and stooling on herself, she is not walking or feeding herself."			

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	Notation dated 9/17/12: "I was informed by group home staff that consumer was not getting better. She is now having a lot of bruising to various areas of her body. Also she is holding her head all of the time." The Conference Summary dated 5/26/10 indicated: "Continues to receive assistance in making major life decisions." The Developmental Assessment dated 5/11/10 indicated: "All of her banking and budgeting procedures must be done with assistance. She cannot be sent on shopping errands. She does no shopping. She does not appear to understand time intervals or equivalents. She does not appear to associate time on the clock with various actions or events." The Individual Support Plan (ISP) dated 4/25/12 indicated: "Individual's Diagnosis: Seizure Disorder, Profound Hearing loss...Comments: Has seizure disorder, condition and medications monitored by neurologist...Profound bilateral hearing loss, has constant ear infections, on medication daily...Receives multiple medications for various physical conditions...GERD-receives medication, Dermatitis-related skin breakdown...Will learn to identify Dilantin and information about it...Will continue to match coins...Will continue to relearn to write			

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	her name...When given the opportunity, will make a purchase." Further review of client #2's record failed to indicate she had any immediate family members that were actively involved. 3. A morning observation was conducted at the group home on 10/9/12 from 5:50 A.M. until 8:05 A.M.. Client #3 sat in a wheelchair and when asked questions began talking about other subjects not related to the questions. A review of client #3's record was conducted at the facility's administrative office on 10/10/12 at 3:40 P.M.. Client #3's record indicated she was an emancipated adult. The Conference Summary dated 12/20/11 indicated: "Needs assistance in making major life decisions." The Developmental Assessment dated 12/20/11 indicated: "Does not use money. Cannot be sent on independent shopping errands. Shops with close supervision. She requires assistance with all banking/budgeting needs. Needs assistance in telling time and does not understand time intervals or equivalents. Does not associate time on a clock with various actions and events. She cannot name the days of the week and refer correctly to morning and afternoon. She does not appear to understand the			

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	difference between day of the week, minute-hour, month-year." The ISP dated 4/19/12 Indicated: Diagnosis: Psychotic Disorder Unspecified, Bipolar Disorder...Will (sic) her money skills by earning to make change for $1.00 using various coins...Will improve her (number) skills by reciting her address...Will improve her academic skills by relearning to print her name...Will improve her health and safety skills by stating the purpose of clozapine." Further review of client #3's record failed to indicate she had any immediate family members that were actively involved. An interview with the Service Coordinator (SC) was completed at the facility's administrative office on 10/12/12 at 12:50 P.M.. The SC indicated clients #1, #2 and #3 did not have legally sanctioned decision makers to assist them with financial and medical decisions. The SC further indicated clients #1, #2 and #3 were incapable of independently managing their finances and unable to independently make financial and medical decisions. 9-3-2(a)			

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W0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview, the facility neglected to implement their neglect policy by neglecting to provide adequate health care for 2 of 3 sampled clients (clients #1 and #2), for their documented health care needs. Findings include: 1. A morning observation was conducted at the group home on 10/9/12 from 5:50 A.M. until 8:05 A.M.. At 6:10 A.M., Direct Support Professional #2 (DSP) walked with her arms around client #2's chest, while standing behind her. Client #2 had an unsteady gait and needed complete assistance from staff while walking to a wheelchair. During the remainder of the observation period, client #2 sat in a wheelchair holding her head. Client #2 did not communicate and when asked questions looked off and then began holding her head with no response. An interview with DSP #2 was conducted on 10/9/12 at 7:00 A.M.. DSP #2 stated client #2 was completely independent and "All of a sudden she just started not doing anything for herself." DSP #2 stated	W0149	The Community Services Nurse will assess all reported injuries or change in physical condition as well as follow up with medical appointments per agency policy. (11/28/12) To ensure future compliance the Service Coordinator will monitor nursing assessment of injuries and pressure sores.	11/28/2012

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	client #2 "had an ear infection and she started having falls and then after her hospitalization for dilantin toxicity, she just regressed and no one knows why." A review of the facility's Bureau of Developmental Disability Services (BDDS) reports was conducted on 10/9/12 at 12:00 P.M.. Review of the reports indicated: Report dated 4/2/12...Date of Knowledge: 4/2/12...Submitted Date: 4/3/12: "[Client #2] was leading (sic) forward so much as she walked a little too quickly that she missed the first step of the bus. [Client #2] fell on the bus step hitting the bridge of her nose and above her left eye..Staff assisted [client #2] up and took her to see the health and safety tech (non nursing staff). The health and safety tech apply (sic) ice pack to left eye which has an inch scratch above the left eye brow. The health tech also apply (sic) antibiotic ointment to the one fourth inch scratch on the bridge of her nose. An ice pack was applied for the beginning swelling of the left eye and to lessen the pain. [Client #2] does not have a fall risk plan." Further review of the record and client #2's medical record did not indicate nursing staff assessed her injuries and did not indicate client #2 was seen by a physician.			

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	Report dated 4/13/12...Date of Knowledge: 4/18/12...Submitted Date: 4/23/12: "Received an incident report stating that [client #2] was walking to the bathroom on 4/13/12 in the home, lost her balance and fell on her knees. Staff checked her over and found no redness, swelling or bruising from the fall at the time...However on 4/15/12 a small dime sized bruise developed on each knee from the fall on 4/13/12 in which staff noticed when assisting [client #2] with her shower...No medical treatment required for the bruises. However, when [client #2] was treated at the ER (Emergency Room) on 4/18/12 for an ear infection, the hospital stated that this caused imbalance and was associated with the fall that occurred. [Client #2] was given medication for the dizziness associated with it." Report dated 5/4/12...Date of Knowledge: 5/15/12...Submitted Date: 5/15/12: "Received an incident report today 5/15/12 dated 5/4/12 stating [client #2] was unsteady on her feet and lost her balance going down to the ground but was caught by staff who eased her down. There was no injury from the fall but [client #2] did sustain a small, 1 inch by 1 inch light purple bruise on her left upper arm from staffs (sic) thumb when they caught her."			

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	Report dated 5/15/12...Date of Knowledge: 5/15/12...Submitted Date: 5/16/12: "Received an incident report from staff that around 2:45 A.M., [client #2] attempted to get out of bed to use the restroom without asking for staff assistance. She fell hitting her face causing a red mark on the bridge of her nose and a 3 inch bruise above her left eyebrow...Follow-Up Report: [Client #2]'s injuries have healed. [Client #2]'s fall risk plan was recently created and therefore is up to date." Report dated 6/5/12: "While getting ready to leave for workshop, [client #2] unhooked the seat belt of her wheelchair and before staff could catch her, fell out of her wheelchair...Staff assisted her back into her chair and did a body check. A scratch on her nose and a bloody nose were what resulted from the fall." Report dated 6/28/12...Date of Knowledge: 6/28/12...Submitted Date: 6/29/12: "Staff at day service reported that [client #2] had a change in mental and physical status. She was disoriented and unable to help herself to eat or toilet...Sent [client #2] to the ER for evaluation and treatment. She was admitted to [Hospital name] for Dilantin toxicity...Follow-Up Report: On 7/5/12 a			

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	debridement was done on a tooth that was found to be infected. The infected tooth was causing distress to her sinus cavity...Dilantin level continues to slowly come down...Follow-Up Report: ...Consumer also seen for initial Physical Therapy evaluation on 7/19/12, plan is to treat once insurance approves treatment....Nursing staff presently considering length of Dilantin Level check orders as ordered by Doctor. Nursing staff will discuss with the IDT (Inter Disciplinary Team) team about more frequent level checks. At this time, we are concerned with the instability of her Dilantin levels, and will request more frequent checks if that's the determination of the IDT team." A review of client #2's record was conducted at the facility's administrative office on 10/10/12 at 3:10 P.M.. Review of client #2's medical record indicated: Notation dated 4/18/12: "[Client #2] was taken by staff to [Hospital name] ER (Emergency Room) because she was very unsteady on her feet and having difficulty walking. DX (Diagnosis) ear infection." Notation dated 5/22/12: "Received an incident report this afternoon from staff stating the [client #2] got up in the night, and without asking for staff assistance			

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	and fell hitting her left eye and nose. Left eye has 3 inch bruise above the eyebrow and nose has a small red area on the bridge. Ice pack applied." Notation dated 6/26/12: "Gait problems...Unable to stand or ambulate...unable to stand." Notation dated 6/27/12: "During a visit at the group home, staff stated there has been a noted change in condition, gait unsteady, occasional confused conversation." Notation Dated 6/28/12: "Patient was admitted for Dilantin toxicity." Notation dated 6/29/12: "Called [Hospital name] for F/U (follow up) on consumer. Consumer doing well, Dilantin level 38.5 (normal range is 10 to 20) at this time." Notation dated 7/2/12: "F/U call to [Hospital name]. Consumer doing well Dilantin level was 19.8. A ENT (Ear Nose and Throat) consult requested due to consumer having a sinus infection." Notation dated 7/15/12: "F/U call to [Hospital name]. Consumer is having procedure of Left Debridement Mastoid cavity done this morning...Dilantin level			

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	is 15.4." Notation dated 7/10/12: "[Client #2] was discharged on 7/9/12. She had a decrease in her Dilantin dose and four new medications." Notation dated 8/20/12: "Staff reported that consumer is getting worst (sic). She is not doing anything for herself. Stated also is wetting and stooling on herself, she is not walking or feeding herself." Notation dated 9/17/12: "I was informed by group home staff that consumer was not getting better she is now having a lot of bruising to various areas of her body. Also she is holding her head all of the time." Further review of client #2's record indicated physician orders to have client #2's Dilantin levels checked on 11/18/11, 1/12/12, 7/18/12, 7/25/12, 7/31/12, 8/9/12 and 9/4/12 (for three weeks). Client #2's record did not indicate if client #2's dilantin orders were completed as ordered on the mentioned dates and did not indicate what client #2's dilantin levels were. 2. A review of client #1's record was conducted at the facility's administrative office on 10/10/12 at 2:35 P.M.. Review			

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	of client #1's medical record indicated: Notation dated 6/27/12: "Nursing assessment performed at client's home...Non-verbal, communicates with minimal sign language...Approximately 1-2 cm (centimeter), 0 depth open area noted to buttock, will obtain order tomorrow." Further review of the record did not indicate further nursing assessments of the mentioned wound and did not indicate an order was obtained to address client #1's wound. The medical record did not indicate if the wound has healed. No documentation was in client #1's record from 6/27/12 until 10/19/12 to address client #1's documented wound. Notation dated 10/1/12: "I received a phone call from group home, DSP (Direct Support Professional) on 9/29/12, stated that consumer went to [Dialysis Center name] for her dialysis treatment. Staff noted that after accessing her dialysis catheter a greenish substance excreted from the dialysis catheter port." No documentation was in the record to indicate how the facility was ordered by the physician to monitor client #1's catheter site and did not indicate when and if the facility nursing staff monitored and assessed client #1's catheter site. Notation dated 10/2/12: "...Consumer			

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	was doing good although admitted due to Sepsis. She has a staph infection in her blood and a UTI (Urinary Tract Infection). Consumer is on two IV (Intravenous) antibiotics." A review of the facility's "Policy for Handling Cases of Neglect and Abuse" dated 12/20/06 was completed at the facility's administrative office on 10/11/12 at 5:30 P.M., and indicated: "In order to protect the general welfare of the clients, ARC Northwest Indiana has in effect the following policy with regard to abuse, neglect or exploitation of clients by agency staff...prohibits all abuse, neglect and exploitation of our clients...Staff will immediately report any allegations of abuse, neglect or exploitation of our clients per agency reporting procedure...Neglect is defined as knowingly placing a client in a situation that poses a threat to his/her health and well being...Examples include, but are not limited to, depriving a client of food, clothing, shelter or medical care." An interview with the Licensed Practical Nurse (LPN) was conducted at the facility's administrative office on 10/12/12 at 12:10 P.M.. The LPN indicated staff should document all incidents of skin breakdown immediately. When asked if client #1 had a sore as			

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	documented, the LPN stated "Yes, she did." When asked what the status of client #1's documented sore was, the LPN stated "I have no idea." The LPN indicated there was no documentation to indicate client #1's documented sore had been assessed and treated. The LPN indicated client #1 was not seen by a physician for her open wound area on her buttock. When asked if there were orders for the care of client #1's catheter site, the LPN stated "I don't know." When asked if nursing staff monitored client #1's catheter site, the LPN stated "No." When asked what the results of client #2's PT assessment were, the LPN stated "She did not have the initial PT assessment due to her medical insurance being inactive." There was no documentation available for review to indicate client #2's ordered PT assessment had been completed to address her documented falls with injury. When asked how often client #2's dilantin levels were ordered to be tested, the LPN stated "I have no idea." When asked what client #2's dilantin levels were for the mentioned physician ordered dates, the LPN stated "I have no idea." 9-3-2(a)			

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W0218	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review and interview, for 1 of 3 sampled clients (client #2) who had unsteady gait with documented falls with injury and used a wheelchair, the facility failed to have a completed assessment that addressed all of client #2's mobility needs. Findings include: A morning observation was conducted at the group home on 10/9/12 from 5:50 A.M. until 8:05 A.M.. At 6:10 A.M., Direct Support Professional #2 (DSP) walked with her arms around client #2's chest, while standing behind her. Client #2 had an unsteady gait and needed complete assistance from staff while walking to a wheelchair. During the remainder of the observation period, client #2 sat in a wheelchair holding her head. Client #2 did not communicate and when asked questions looked off and then began holding her head with no response. A review of client #2's record was conducted at the facility's administrative office on 10/10/12 at 3:10 P.M.. Review of client #2's medical record indicated: Notation dated 4/18/12: "[Client #2] was	W0218	Client #2 attended a complete physical therapy evaluation. Recommendation is for a gait belt. Community Services Nurse and Service Coordinator will ensure a gait belt is ordered and that client receives the gait belt. Community Services Nurse and/or Service Coordinator will train DSPs on proper use of gait belt. (11/28/12) To ensure future compliance, Service Coordinator and nursing staff will follow-up on all rescheduled appointments to ensure they are completed within the time allowed by state requirements.	11/28/2012

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	taken by staff to [Hospital name] ER (Emergency Room) because she was very unsteady on her feet and having difficulty walking. DX (Diagnosis) ear infection." Notation dated 5/22/12: "Received an incident report this afternoon from staff stating the [client #2] got up in the night, and without asking for staff assistance and fell hitting her left eye and nose. Left eye has 3 inch bruise above the eyebrow and nose has a small red area on the bridge. Ice pack applied." Notation dated 6/26/12: "Gait problems...Unable to stand or ambulate...unable to stand." Notation dated 6/27/12: "During a visit at the group home, staff stated there has been a noted change in condition, gait unsteady, occasional confused conversation." Notation date 7/17/12: "Patient seen for initial examination (Physical Therapy). Patient is dependent with transfer and ambulation. Further review did not indicate the PT assessment had been conducted/completed. No recommendations were noted in client #2's record. Notation dated 8/20/12: "Staff reported			

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	that consumer is getting worst (sic). She is not doing anything for herself. Stated also is wetting and stooling on herself, she is not walking or feeding herself." Further review of client #2's record failed to have an assessment that addressed her mobility needs. An interview with the Licensed Practical Nurse (LPN) was conducted at the facility's administrative office on 10/12/12 at 12:10 P.M.. When asked what the results of client #2's PT assessment were, the LPN stated "She did not have the initial PT assessment due to her medical insurance being inactive." There was no documentation available for review to indicate client #2's ordered PT assessment had been conducted/completed to address her use of a wheelchair at all times for mobility and to address her documented falls with injury. The LPN indicated as of 10/12/12 client #2 did not have a PT assessment completed. 9-3-4(a)			

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W0318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview, the Condition of Participation, Health Care Services, is not met as the facility failed to provide adequate nursing services for 2 of 3 sampled clients (clients #1 and #2). Findings include: Please refer to W331. The facility nursing services failed for 2 of 3 sampled clients (clients #1 and #2) by not ensuring they received nursing services according to their medical needs. 9-3-6(a)	W0318	Refer to tag 33112/5/12Community Services Nurse sees clients once a week either at Day Services or at the home. The nurse will make an assessment for all changes of conditionor injuries within 24 hours. The Community Services Director is in charge of nursing at this time. The expectation is that the Nurse will make regular visits to both home and Day Services on a weekly basis and assess clients within 24 hours for any changes in condition. This information is then given to the Community Services Director, Service Director and Behavioral Health Director to ensure the team is aware of the situation.To ensure future compliance, the Nurse and Service Coordinator will monitor the clients weekly as well as assessing any changes or injuries within twenty four hours.	11/27/2012

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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview, the facility nursing services failed for 2 of 3 sampled clients (clients #1 and #2) by not ensuring they received nursing services according to their medical needs. Findings include: 1. A morning observation was conducted at the group home on 10/9/12 from 5:50 A.M. until 8:05 A.M.. At 6:10 A.M., Direct Support Professional #2 (DSP) walked with her arms around client #2's chest, while standing behind her. Client #2 had an unsteady gait and needed complete assistance from staff while walking to a wheelchair. During the remainder of the observation period, client #2 sat in a wheelchair holding her head. Client #2 did not communicate and when asked questions looked off and then began holding her head with no response. An interview with DSP #2 was conducted on 10/9/12 at 7:00 A.M.. DSP #2 stated client #2 was completely independent and "All of a sudden she just started not doing anything for herself." DSP #2 stated client #2 "had an ear infection and she started having falls and then after her	W0331	Community Services Nurse will assess all changes in client condition and schedule Dr appointments as necessary. To ensure future compliance, Service Coordinator will make bi-weekly visits to group homes to monitor clients for any change in condition. 12/5/12Community Services Nurse sees clients once a week either at Day Services or at the home. The nurse will make an assessment for all changes of conditionor injuries within 24 hours. The Community Services Director is in charge of nursing at this time. The expectation is that the Nurse will make regular visits to both home and Day Services on a weekly basis and assess clients within 24 hours for any changes in condition. This information is then given to the Community Services Director, Service Director and Behavioral Health Director to ensure the team is aware of the situation.To ensure future compliance, the Nurse and Service Coordinator will monitor the clients weekly as well as assessing any changes or injuries within twenty four hours.	11/27/2012

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	hospitalization for dilantin toxicity, she just regressed and no one knows why." A review of the facility's Bureau of Developmental Disability Services (BDDS) reports was conducted on 10/9/12 at 12:00 P.M.. Review of the reports indicated: Report dated 4/2/12...Date of Knowledge: 4/2/12...Submitted Date: 4/3/12: "[Client #2] was leading (sic) forward so much as she walked a little too quickly that she missed the first step of the bus. [Client #2] fell on the bus step hitting the bridge of her nose and above her left eye..Staff assisted [client #2] up and took her to see the health and safety tech (non nursing staff). The health and safety tech apply (sic) ice pack to left eye which has an inch scratch above the left eye brow. The health tech also apply (sic) antibiotic ointment to the one fourth inch scratch on the bridge of her nose. An ice pack was applied for the beginning swelling of the left eye and to lessen the pain. [Client #2] does not have a fall risk plan." Further review of the record and client #2's medical record did not indicate nursing staff assessed her injuries and did not indicate client #2 was seen by a physician. Report dated 4/13/12...Date of Knowledge: 4/18/12...Submitted Date:			

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	4/23/12: "Received an incident report stating that [client #2] was walking to the bathroom on 4/13/12 in the home, lost her balance and fell on her knees. Staff checked her over and found no redness, swelling or bruising from the fall at the time...However on 4/15/12 a small dime sized bruise developed on each knee from the fall on 4/13/12 in which staff noticed when assisting [client #2] with her shower...No medical treatment required for the bruises. However, when [client #2] was treated at the ER (Emergency Room) on 4/18/12 for an ear infection, the hospital stated that this caused imbalance and was associated with the fall that occurred. [Client #2] was given medication for the dizziness associated with it." Further review of the report did not indicate the nursing staff assessed client #2 after the reported fall on 4/13/12. Report dated 5/4/12...Date of Knowledge: 5/15/12...Submitted Date: 5/15/12: "Received an incident report today 5/15/12 dated 5/4/12 stating [client #2] was unsteady on her feet and lost her balance going down to the ground but was caught by staff who eased her down. There was no injury from the fall but [client #2] did sustain a small, 1 inch by 1 inch light purple bruise on her left upper arm from staffs (sic) thumb when they			

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	caught her." Further review of the report did not indicate nursing staff assessed client #2' documented unsteady gait. Report dated 5/15/12...Date of Knowledge: 5/15/12...Submitted Date: 5/16/12: "Received an incident report from staff that around 2:45 A.M., [client #2] attempted to get out of bed to use the restroom without asking for staff assistance. She fell hitting her face causing a red mark on the bridge of her nose and a 3 inch bruise above her left eyebrow...Follow-Up Report: [Client #2]'s injuries have healed. [Client #2]'s fall risk plan was recently created and therefore is up to date." Further review of client #2's record failed to indicate a fall risk plan. Report dated 6/5/12: "While getting ready to leave for workshop, [client #2] unhooked the seat belt of her wheelchair and before staff could catch her, fell out of her wheelchair...Staff assisted her back into her chair and did a body check. A scratch on her nose and a bloody nose were what resulted from the fall." Further review of the report failed to indicate a nursing assessment was completed. Report dated 6/28/12...Date of Knowledge: 6/28/12...Submitted Date:			

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	15G696	A. BUILDING 00 B. WING	10/19/2012

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	6/29/12: "Staff at day service reported that [client #2] had a change in mental and physical status. She was disoriented and unable to help herself to eat or toilet...Sent [client #2] to the ER for evaluation and treatment. She was admitted to [Hospital name] for Dilantin toxicity...Follow-Up Report: On 7/5/12 a debridement was done on a tooth that was found to be infected. The infected tooth was causing distress to her sinus cavity...Dilantin level continues to slowly come down...Follow-Up Report: ...Consumer also seen for initial Physical Therapy evaluation on 7/19/12, plan is to treat once insurance approves treatment....Nursing staff presently considering length of Dilantin Level check orders as ordered by Doctor. Nursing staff will discuss with the IDT (Inter Disciplinary Team) team about more frequent level checks. At this time, we are concerned with the instability of her Dilantin levels, and will request more frequent checks if that's the determination of the IDT team." Further review did not indicate if the IDT met and addressed client #2's change in status. A review of client #2's record was conducted at the facility's administrative office on 10/10/12 at 3:10 P.M.. Review of client #2's medical record indicated:			

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	Notation dated 4/18/12: "[Client #2] was taken by staff to [Hospital name] ER (Emergency Room) because she was very unsteady on her feet and having difficulty walking. DX (Diagnosis) ear infection." Notation dated 5/22/12: "Received an incident report this afternoon from staff stating the [client #2] got up in the night, and without asking for staff assistance and fell hitting her left eye and nose. Left eye has 3 inch bruise above the eyebrow and nose has a small red area on the bridge. Ice pack applied." Notation dated 6/26/12: "Gait problems...Unable to stand or ambulate...unable to stand." Notation dated 6/27/12: "During a visit at the group home, staff stated there has been a noted change in condition, gait unsteady, occasional confused conversation." Notation Dated 6/28/12: "Patient was admitted for Dilantin toxicity." Notation dated 6/29/12: "Called [Hospital name] for F/U (follow up) on consumer. Consumer doing well, Dilantin level 38.5 (normal range is 10 to 20) at this time."			

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	Notation dated 7/2/12: "F/U call to [Hospital name]. Consumer doing well Dilantin level was 19.8. A ENT (Ear Nose and Throat) consult requested due to consumer having a sinus infection." Notation dated 7/15/12: "F/U call to [Hospital name]. Consumer is having procedure of Left Debridement Mastoid cavity done this morning...Dilantin level is 15.4." Notation dated 7/10/12: "[Client #2] was discharged on 7/9/12. She had a decrease in her Dilantin dose and four new medications." Notation dated 8/20/12: "Staff reported that consumer is getting worst (sic). She is not doing anything for herself. Stated also is wetting and stooling on herself, she is not walking or feeding herself." Notation dated 9/17/12: "I was informed by group home staff that consumer was not getting better she is now having a lot of bruising to various areas of her body. Also she is holding her head all of the time." Further review of client #2's record indicated physician orders to have client #2's Dilantin levels checked were written on 11/18/11, 1/12/12, 7/18/12, 7/25/12,			

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	7/31/12, 8/9/12 and 9/4/12 (for three weeks). Client #2's record did not indicate if client #2's dilantin orders were completed as ordered on the mentioned dates and did not indicate what client #2's dilantin levels were. 2. A review of client #1's record was conducted at the facility's administrative office on 10/10/12 at 2:35 P.M.. Review of client #1's medical record indicated: Notation dated 6/27/12: "Nursing assessment performed at client's home...Non-verbal, communicates with minimal sign language...Approximately 1-2 cm (centimeter), 0 depth open area noted to buttock, will obtain order tomorrow." Further review of the record did not indicate further nursing assessments of the mentioned wound and did not indicate an order was obtained to address client #1's wound. The medical record did not indicate if the wound had healed. No documentation was in client #1's record from 6/27/12 until 10/19/12 to address client #1's documented wound. Notation dated 10/1/12: "I received a phone call from group home, DSP (Direct Support Professional) on 9/29/12, stated that consumer went to [Dialysis Center name] for her dialysis treatment. Staff noted that after accessing her dialysis			

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	catheter a greenish substance excreted from the dialysis catheter port." No documentation was in the record to indicate how the nursing staff was ordered by the physician to monitor client #1's catheter site and did not indicate when and if the facility nursing staff monitored and assessed client #1's catheter site. Notation dated 10/2/12: "...Consumer was doing good although admitted due to Sepsis. She has a staph infection in her blood and a UTI (Urinary Tract Infection). Consumer is on two IV (Intravenous) antibiotics." An interview with the Licensed Practical Nurse (LPN) was conducted at the facility's administrative office on 10/12/12 at 12:10 P.M.. The LPN indicated staff should document all incidents of skin breakdown immediately. When asked if client #1 had a sore as documented, the LPN stated "Yes, she did." When asked what the status of client #1's documented sore was, the LPN stated "I have no idea." The LPN indicated there was no documentation to indicate client #1's documented sore had been assessed and treated. The LPN indicated client #1 was not seen by a physician for her open wound area on her buttock. When asked if there were orders			

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	for the care of client #1's catheter site, the LPN stated "I don't know." When asked if nursing staff monitored client #1's catheter site, the LPN stated "No." When asked what the results of client #2's PT assessment were, the LPN stated "She did not have the initial PT assessment due to her medical insurance being inactive." There was no documentation available for review to indicate client #2's ordered PT assessment had been completed to address her documented falls with injury. When asked how often client #2's dilantin levels were ordered to be tested, the LPN stated "I have no idea." When asked what client #2's dilantin levels were for the mentioned physician ordered dates, the LPN stated "I have no idea." An interview with the group home nurse was conducted on 10/12/12 at 12:10 P.M.. The nurse indicated there was no documentation available for review to indicate the nursing staff requested orders for client #2's Dilantin to be tested regularly. When asked if the facility nursing staff assessed client #2 after each of the documented falls, she stated "No." When asked if client #2 had the PT assessment completed as ordered, she stated "No, because at the time there were problems with her insurance." When asked if the facility nursing staff monitored and assessed client #1's PIC			

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	line for dialysis treatment, she stated "No." When asked if there was any documentation available for review to indicate all staff working with clients #1 and #2 were trained on their medical needs, she indicated there was not. When asked if there was any documentation available for review to indicate nursing staff monitored and changed dressing of client #1's documented wound, the nurse answered "No." No documentation was submitted for review to indicate the facility's nursing staff provided nursing services for clients #1 and #2's documented medical concerns. 9-3-6(a)			

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W0369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview, the facility failed for 2 of 17 medications administered to 2 of 3 clients observed during medication administration (clients #4 and #5) to administer medications as ordered without error. Findings include: 1. A morning observation was conducted at the group home on 10/9/12 from 5:50 A.M. until 8:05 A.M.. At 7:20 A.M., client #4 received her morning prescribed medications. Direct Support Professional (DSP) #2 administered her "Aspirin 81 mg (milligram) (pain) chew tablet...1 tablet orally once a day...chew tablet before swallowing...Take with food/meal." Client #4 swallowed her medication. Client #4 was not prompted to chew and did not chew her medication and did not take her medication with food/meal. Client #4 ate her breakfast at 8:00 A.M.. 2. At 7:25 A.M., client #5 received her morning prescribed medications. DSP #2 administered her "Ziprasidone 60 mg	W0369	The Community Service Nurse will re-train DSP's on how to follow medication orders and record results on Medication Administration Record in accordance with physician's order. (11/28/12) To ensure future compliance the Community Services Nurse will visit group home at least bi-monthly for three months and at least quarterly thereafter. 12/5/12The Community Service Nurse will re-train DSP's on how to follow medication orders and record results on Medication Administration Record in accordance with physician's order. The Nurse will view two medication passes per month to ensure that the Dr's medication orders are followed. This is different because this training focused more on the need for meal time consideration when giving medications. The system failed in that the staff failed to give consideration to medications requiring food or to be given on an empty stomach. To ensure future compliance, the Community Services Nurse and Service Coordinator will visit group home at least twice monthly for three months and at least twice monthly thereafter.	11/28/2012

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	capsule (antipsychotic)...1 capsule orally twice daily...Take with meals. Client #5 did not take her medication with food/meal. Client #5 ate breakfast at 8:00 A.M.. A review of "Nursing Spectrum Drug Handbook" dated 2010 was conducted on 10/9/12 at 8:00 P.M.. Review of the handbook indicated: "Aspirin...Give with food. Ziprasidone Hydrochloride...Therapeutic class: Antipsychotic...Administration: Give with food." An interview with the nurse was conducted on 10/12/12 at 12:10 P.M.. The nurse indicated staff should administer all medications as prescribed. The nurse further indicated staff should follow directions on medication labels on medication packets. 9-3-6(a)			

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W0388	483.460(m)(1)(i) DRUG LABELING Labeling for drugs and biologicals must be based on currently accepted professional principles and practices. Based on observation, record review, and interview, the facility failed for 1 of 3 clients observed during morning medication administration (client #3) to have the medication labeled from the pharmacy. Findings include: A morning observation was conducted at the group home on 10/9/12 from 5:50 A.M. until 8:05 A.M.. Client #3's medications were administered by Direct Support Professional (DSP) #2 at 7:36 A.M.. A bottle of Proair 90 mcg (micrograms) Inhaler was taken from client #3's clear plastic medication bin. The bottle did not contain client #3's name or instructions for administration. The inhaler was not in packaging with a label. The bottle did not contain a pharmacy label. Review of the Medication Administration Record (MAR) dated 10/1/12 to 10/31/12 was conducted on 10/9/12 at 7:40 A.M. and indicated: "Proair 90 mcg Inhaler...2 puffs daily." An interview with the Licensed Practical Nurse (LPN) was conducted on 10/12/12	W0388	Community Services Nurse will re-train DSP's on keeping medications in the labeled boxes and getting new labels for all missing or damaged labels. Staff will be re-trained to keep medication in labeled container when the method of dispensation is not conducive to labeling. (11/28/12) To ensure future compliance, Community Services Nurse and/or Service Coordinator will check medication storage and labeling at least bi-monthly for three months and at least quarterly thereafter. 12/5/12Community Services Nurse willl re-train DSP's on keeping medications in the labeled boxes and getting new labels for all missing or damaged labels. Staff will be re-trained to keep medication in labeled container when the method of dispensation is not conducive to labeling. If a box with a label is not available, Nurse will secure a label from the pharmacy. To ensure future compliance, Community Services Nurse and/or Service Coordinator will check medication storage and labeling at least weekly for three months and at least quarterly thereafter.	11/28/2012

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	at 12:10 P.M.. The LPN indicated all medications should have a pharmacy label on them. 9-3-6(a)			

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W0436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, the facility failed to provide eyeglasses for 2 of 3 sampled clients (clients #2 and #3) who required eyeglasses. Findings include: A morning observation was conducted at the group home on 10/9/12 from 5:50 A.M. until 8:05 A.M.. During the observation period, clients #2 and #3 did not wear prescribed eyeglasses. At 6:50 A.M., client #3 asked Direct Support Professional (DSP) #1 when she was going to get her eyeglasses. DSP #1 stated "I don't know." An evening observation was conducted at the group home on 10/9/12 from 5:00 P.M. until 7:05 P.M.. During the entire observation period, clients #2 and #3 did not wear prescribed eyeglasses. A facility owned day program observation was conducted on 10/12/12 from 2:00 P.M. until 3:00 P.M.. During the	W0436	There was an error in the chart indicating client #3 wears glasses. Client #3 does not. Client #2's glasses are back from repair. The Service Coordinator will retrain DSPs on importance of adaptive equipment to ensure clients are making informed choices about their adaptive equipment. (11/28/12) To ensure future compliance, The Service Coordinator will monitor use of adaptive equipment at least bi-monthly thereafter.	11/28/2012

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	observation period clients #2 and #3 did not wear prescribed eyeglasses. An interview with day program staff #1 was conducted on 10/12/12 at 2:45 P.M.. Day program staff #1 indicated client #3's eyeglasses have been missing for over 2 months and she has never seen client #2 wear eyeglasses. Client #2's record was reviewed on 10/10/12 at 3:10 P.M.. A review of client #2's 12/22/10 vision exam indicated the client was prescribed eyeglasses to wear due to myopia (nearsightedness) and nystagmus (uncontrolled movement of eye). Entry dated 5/25/12 indicated: "Glasses adjusted." Her most current "Nursing Quarterly" dated 7/11/12 indicated "Glasses" checked. Client #3's record was reviewed on 10/10/12 at 3:40 P.M.. A review of client #3's 12/20/11 vision exam indicated the client was prescribed eyeglasses. The Individual Support Plan (ISP) dated 4/19/12 indicated: "Wears eyeglasses. These are repaired/replaced as needed. An interview with the group home Licensed Practical Nurse (LPN) was conducted on 10/12/12 at 12:10 P.M.. The LPN stated clients #2 and #3's eyeglasses were "probably sent out for			

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	repair." 9-3-7(a)			

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W9999	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: 460 IAC 9-3-1(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division. This state rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to report skin breakdown and falls with injury involving 2 of 3 sampled clients (clients #1 and #2) to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner. Findings include: A review of the facility's records was conducted at the facility's administrative office on 10/9/12 at 12:00 P.M.. Review of the facility's BDDS reports failed to include any incidents of skin break down involving the clients at this group home.	W9999	Service Coordinator and/or Community Services Nurse will report incidents to BDDS within a 24 hour period after receiving notification of reportable incident. All incidents will be reported to the administrator immediately upon notification. (11/28/12) To ensure future compliance Service Coordinator and/or Community Services Nurse will report all BDDS worthy incidents within twenty-four hours of notification of incident.	11/28/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G696	A. BUILDING 00 B. WING	10/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	336 W 56TH ST MERRILLVILLE, IN 46410

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	Further review of the BDDS reports indicated: Report dated 4/13/12...Date of Knowledge: 4/18/12...Submitted Date: 4/23/12: "Received an incident report stating that [client #2] was walking to the bathroom on 4/13/12 in the home, lost her balance and fell on her knees. Staff checked her over and found no redness, swelling or bruising from the fall at the time...However on 4/15/12 a small dime sized bruise developed on each knee from the fall on 4/13/12 in which staff noticed when assisting [client #2] with her shower...No medical treatment required for the bruises. However, when [client #2] was treated at the ER (Emergency Room) on 4/18/12 for an ear infection, the hospital stated that this caused imbalance and was associated with the fall that occurred. [Client #2] was given medication for the dizziness associated with it." A review of client #1's record was conducted at the facility's administrative office on 10/10/12 at 2:35 P.M.. Review of client #1's medical record indicated: Notation dated 6/27/12: "Nursing assessment performed at client's home...Non-verbal, communicates with minimal sign language...Approximately			

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	1-2 cm (centimeter), 0 depth open area noted to buttock, will obtain order tomorrow." Further review did not indicate the noted wound was reported to BDDS. A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 10/11/12 at 5:00 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS...Incidents to be reported to BQIS include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual including but not limited to: Any occurrence of skin breakdown related to a decubitus ulcer, regardless of the severity...A fall resulting in injury, regardless of the severity of the injury." An interview with LPN #1 was conducted on 10/12/12 at 12:10 P.M.. LPN #1 indicated incidents of skin breakdown should be reported within 24 hours to BDDS. The LPN further indicated client #2's incident was not reported timely to			

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